



GEORGIA MEDICAID FEE-FOR-SERVICE CABOMETYX PA SUMMARY

Preferred	Non-Preferred
Cabometyx (cabozantinib)	n/a

LENGTH OF AUTHORIZATION: 1 Year

PA CRITERIA:

- ❖ Approvable for members 18 years of age or older with a diagnosis of advanced renal cell carcinoma (kidney cancer) whose cancer has relapsed or is in stage IV, is surgically unresectable and cell histology is predominantly clear

AND

- ❖ Member has progressed or relapsed after therapy with axitinib (Inlyta), pazopanib (Votrient), sorafenib (Nexavar) or sunitinib (Sutent).

EXCEPTIONS:

- ❖ Exceptions to these conditions of coverage are considered through the prior authorization process.
- ❖ The Prior Authorization process may be initiated by calling **OptumRx at 1-866-525-5827**.

PREFERRED DRUG LIST:

- ❖ For online access to the Preferred Drug List (PDL), please go to <http://dch.georgia.gov/preferred-drug-lists>.

PA AND APPEAL PROCESS:

- ❖ For online access to the PA process, please go to www.dch.georgia.gov/prior-authorization-process-and-criteria and click on Prior Authorization (PA) Request Process Guide.

QUANTITY LEVEL LIMITATIONS:

- ❖ For online access to the current Quantity Level Limits (QLL), please go to www.mmis.georgia.gov/portal, highlight Provider Information and click on Provider Manuals. Scroll to the page with Pharmacy Services and select that manual.